STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155549	A. BUILDING _____ B. WING _____	R-C 07/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBEND LIVING CENTER	**7524 E JACKSON ST MUNCIE, IN 47302**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00151176 completed on 6/26/14.

Complaint IN00151176 - Corrected

Survey date: July 25, 2014

Facility number: 000681
Provider number: 155549
AIM number: 100286100

Surveyor:
Betty Retherford RN

Census bed type:
SNF/NF: 37
Total: 37

Census payor type:
Medicare: 1
Medicaid: 36
Total: 37

Sample: 4

Willowbend Living Center was found to be in compliance with 42 CFR Part 483, subpart B and 410 IAC 16.2-3.1 in regards to the PSR to the Investigation of Complaint IN00151176.

Quality review completed by Debora Barth, RN.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE